

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

July 14, 2003

**Re: IRO Case # M2-03-1311-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Management. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient was injured on \_\_\_ while pushing a soda machine. He developed pain across the back and into the left leg. He eventually had a fusion in June 2002. Follow-up notes mention possible pseudoarthrosis, although no further surgery is anticipated. The patient was placed at MMI on 5/27/03 with a 10% disability rating. The patient states that the fusion did not alleviate his pain. The patient began treatment with a stimulator beginning 3/1/03.

Requested Service(s)

Purchase of RS4i sequential stimulator 4 channel

### Decision

I agree with the carrier's decision to deny the requested treatment.

### Rationale

Only a small amount of subjective evidence indicating that the patient reported improved function and decreased medication usage was in the documentation presented for this review. The patient had not returned to work. The request is for a 4-channel system, but in the trial the patient has not used more than two channels consistently. The first month's usage was 60% of days, and the second month's usage was 33% of days, according to reports. There was decreased usage after only one month. In summary, no objective evidence of decreased pain such as documented medication decrease was reported. The patient has already decreased usage of the device and is not utilizing all four channels. Most importantly, no documentation of improved function was in the records provided for review.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

## **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:  
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669,  
Austin, TX 78704-0012.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308(t)(2)).

Sincerely,

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In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 16<sup>th</sup> day of July 2003.